STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG	00	COMPL	ETED
		155755	A. BUII B. WIN	LDING		07/15/2	011
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	ROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP CODE		
001 051	. VE A DO LIONATOT	EAD.		1	OEGLEIN ROAD		
GOLDEN	YEARS HOMEST	EAD		FORT	WAYNE, IN46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
			F0	0000	Ms. Kim Rhoades Indiana S	tate	
	This visit was fo	or a Recertification and			Department of Health 2 Nort	:h	
					Meridian Street Indianapolis		
	State Licensure	Survey.			46204Dear Ms. Rhoades: Pl		
	C	-L- 11 12 12 14 0 15			find our Plan of Correction for		
	_	ıly 11, 12, 13, 14, & 15,			our Annual Survey conducte		
	2011.				our community July 11-15, 2		
					Our date of compliance is Au 13, 2011. Please contact me	•	
	Facility number:	000282			you need any further informa		
	Provider number	r: 155755			or details. Sincerely, Dianna		
	AIM number: 0	00287520			Holmes, MSW, HFA Adminis		
	rinvi namoci.	00207320			The creation and submission		
	G .				this Plan of Correction does	not	
	Survey team:				constitute an admission by t	his	
	Sue Brooker, RI	D-TC			provider of any conclusion s	et	
	Rick Blain, RN				forth in the statement of		
	Sheryl Roth, RN				deficiencies, or of any violati	on of	
	Angie Strass, RN				regulation. This Plan of		
					Correction is prepared and submitted because of		
	Communa had trung				requirements under State ar	nd	
	Census bed type	•			Federal law. This provider	IU	
	SNF/NF: 103				respectfully requests that the	9	
	Total: 103				2567 Plan of Correction be	-	
					considered the Letter of Cre	dible	
	Census payor ty	pe:			Allegation and requests a Po	ost	
	Medicare: 4	•			Survey Review on or after A	ugust	
	Medicaid: 79				13, 2011.		
	Other: 20						
	Total: 103						
	Sample: 21						
	These deficienci	es also reflect state					
		accordance with 410 IAC					
	_	accordance with 410 IAC					
	16.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YFM811

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 07/15/2	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN ROAD FORT WAYNE, IN46815				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Quality review completed on July 18, 2011 by Bev Faulkner, RN		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0223 SS=A	verbal, sexual, phy corporal punishme seclusion. The facility must n sexual, or physical punishment, or inverse facility failed to or physical abuse diresidents reviewed of 21. (Resident Findings include Resident #104's a Resident #104's a Resident #104's a were not limited chronic obstruction Alzheimer's Dem hypothyroidism.	review and interview, the ensure an incident of d not occur for 1 of 21 ed for abuse in a sample #104) record was reviewed on .m. The record indicated diagnoses included, but to, high blood pressure, we pulmonary disease,	F0	223	F 0223It is the practice of this provider to ensure residents the right to be free from verb sexual, physical, and mental abuse, corporal punishment, involuntary seclusion. This provider does not allow verb mental, sexual, or physical a corporal punishment, or involuntary seclusion. What corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice? This resident is no longer in the facility. How will identify other residents hav the potential to be affected what corrective action will be taken? The employees were immediately terminated there no other residents had the potential to be affected by the	have al, and al, buse, you ring by and oe	08/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155755	B. WIN			07/15/2	011
NAME OF	DD OT HDED OD GUDDI IEI	`		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	C		3136 G	OEGLEIN ROAD		
	N YEARS HOMEST			<u> </u>	VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	"	he shower, the resident			alleged deficient practice. W		
	indicated "Look	what they did to me" and			measures will be put into p		
	showed the care	givers her right hand/wrist			or what systemic changes y will make to ensure that the	-	
	bruise. The resid	dent then indicated "they			deficient practice does not		
	1	own". Both caregivers			recur? This provider's system		
		ident was combative and			as follows: Pre-employment		
		e caregivers arms.			interviews are conducted,		
	liad scratched the	e caregivers arms.			Pre-employment reference		
	Th. "F	ident Dementing France!!			checks are conducted,		
	1	eident Reporting Form,"			Employment criminal backgr	ound	
	1	idicated "resident			checks are completed, Employees are trained upon	hiro	
	reported to (nam	-			and routinely thereafter on a		
	employees (nam	e of employee) and (name			and neglect policy and proce		
	of employee) con	ntinued giving her a			Proper authorities are notifie		
	shower despite r	esident becoming agitated			abuse and neglect allegation	ıs,	
	and wanting to n	ot continue to			This provider has a zero		
	1	nt reported 'They held my			tolerance for abuse and negl		
	1	ose 2 young girls did that			therefore any allegations of sincidents will warrant immed		
		t was combative during			termination. How the correc		
	1	nt is on daily aspirin, has			action(s) will be monitored		
		• •			ensure the deficient practic		
	1 -	sident sustained purple			will not recur, i.e., what qua		
	1 -	bilateral hand, wrist and			assurance program will be	-	
		six areas(name of			into place: All staff will		
	staff) immediate	ly suspendedgave			be in-serviced by		
	written statemen	ts prior to departure with			the Administrator and/or Dire	ector	
	neither admitting	g to holding down			of Nursing Services or designees on July 28 and Au	iquet	
	1 3	ooth confirmed she was			1, 2011 regarding this provid	•	
	combative and c	hoosing unsafe decisions			abuse and neglect policy and		
		get out of showerCNA's			procedure, caring for comba		
		olicy of zero tolerance for			residents and resident rights		
		of abuse or neglect			Administrator or designee wi		
	1 *	· ·			monitor continued compliand	е	
	substantiated or	unsubstantiated"			through monthly random employee interviews and		
					observations regarding our a	ibuse	
	_	iew with the Health			and neglect policy, caring for		
	Facility Adminis	strator (HFA) on 7/15/11					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/15/2011
	PROVIDER OR SUPPLIER		3136 G	ADDRESS, CITY, STATE, ZIP CODE OEGLEIN ROAD WAYNE, IN46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	at 9:00 a.m., the members were to	HFA indicated both staff erminated due to the zero facility on abuse.		combative residents and resights x 6 months. The Administrator will document findings on a Quality Improvement Tool and reporteresults of this audit to the CASSURANCE committee who determine the frequency of further audits.	sident' t ort the quality

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DI III	DDIG	00	COMPL	ETED
		155755	A. BUIL B. WING			07/15/2	011
			B. WINC		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER						
COLDEN	LVEADO LIOMECTI	- 4 D			DEGLEIN ROAD		
GOLDEN	I YEARS HOMESTE	EAD		FORTW	VAYNE, IN46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0278 SS=D	The assessment must accurately reflect the resident's status.						
		must conduct or coordinate with the appropriate alth professionals.					
	A registered nurse the assessment is	must sign and certify that completed.					
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS) Assessment for 2 of 21 residents related to eating (Resident #91 and #104) and failed to accurately code the MDS for bed mobility for 1 of 21 residents reviewed for bed mobility (Resident #88) in a sample of 21. Findings include:						
			F02	278	It is the practice of this provio complete assessments that accurately reflect the residen status. A registered nurse conducts or coordinates each assessment with the appropr participation of health professionals. A registered r signs and certifies the assessment is completed. E individual who completes a portion of the assessment sig and certifies the accuracy of portion of the assessment.W corrective action(s) will be	t's n riate nurse ach gns that	08/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155755 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3136 GOEGLEIN ROAD **GOLDEN YEARS HOMESTEAD** FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 1. Resident #88's record was reviewed on accomplished for those residents found to have been affected by 7/11/11 at 2:05 p.m. The record indicated the deficient practice? Residents Resident #88's diagnoses included, but #88, #91 and #104 's most recent were not limited to, high blood pressure, MDS's were audited, modified if required and resubmitted. All heart disease and fractured hip. were accepted upon resubmission. How will you The quarterly Minimum Data Set (MDS) identify other residents having the Assessment, dated 6/1/11, indicated potential to be affected by the Resident #88 performed bed mobility only same deficient practice and what corrective action will be once or twice during the one week taken?100% of our residents observation period. latest MDS's that were previously transmitted have been audited. The "ADL Grid" (activities of daily modified if required and resubmitted. All were accepted living), dated 5/26/11 through 6/1/11, upon resubmission.What indicated Resident #88 was independent measures will be put into place or for bed mobility 7 of 7 times on nights, 7 what systemic changes you will make to ensure that the deficient of 7 times on days, and 6 of 7 times on practice does not recur? Our evenings. MDS Coordinator contacted Barb Wheeler, State of Indiana RAI 2. Resident #104's record was reviewed Coordinator, for further on 7/14/11 at 8:45 a.m. The record clarification, training and quidance on the issues indicated Resident #104's diagnoses identified. We completely included, but were not limited to, high understand this part of the system blood pressure, Alzheimer's dementia and therefore will not have a chronic obstructive pulmonary disease. reoccurence of the alleged deficient practice. How the corrective action(s) will be The significant change MDS, dated monitored to ensure the deficient 3/1/11, indicated Resident #104 practice will not recur, i.e., what participated in eating only once or twice quality assurance program will be put into place: Our MDS during the one week observation period. Coordinator will audit monthly x 6 The narrative report for the 3/1/11 MDS months the four late loss ADL's indicated Resident #104 continued on a on all transmitted MDS's to be no added salt diet which she would feed certain of accuracy. The Administrator will document to herself after set up by staff.

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155755	B. WIN			07/15/2	011
		II.	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			OEGLEIN ROAD		
GOLDEN	YEARS HOMEST	EAD		1	VAYNE, IN46815		
				ID	,		(V.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
					findings on a Quality		
	The WADI Codd	II data d 2/22/11 through			Improvement Tool and report	t the	
	1	" dated 2/23/11 through			results of this audit to the Qu		
	· ·	Resident #104 was			Assurance committee who w	rill .	
	1 ^	n eating 6 of 7 times on			determine the frequency		
	days and require	d only supervision on 1 of			of further audits.		
	7 days. The "AI	DL Grid" for evenings,					
	indicated the res	ident was independent					
	with eating on 6	of 7 times on evenings					
	and required con	nprehensive assistance for					
	1 of 7 times on e	evenings.					
	3 Resident #91	's record was reviewed on					
		o.m. The record indicated					
	_	iagnoses included, but					
		to, depression, chronic					
		ionary disease and					
	_	_					
	coronary artery of	iisease.					
	TTI : : C .	1 MDC 1 / 1					
	_	change MDS, dated					
	4/26/11, indicate						
	1 -	ating only once or twice					
	_	reek observation period.					
	The narrative rep	port for the 4/26/11 MDS					
	indicated Reside	nt #91 continued on a no					
	added salt diet w	hich she ate in the unit					
	dining room.						
	The "ADL Grid.	" dated 4/20/11 through					
		ed Resident #91 was					
	independent with eating 7 of 7 times						
	during the day. The "ADL Grid" for						
	evenings, indicated the resident was						
	independent with eating 5 of 7 times and						
	_	_					
	required limited	assistance 2 of 7 times on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155755	A. BUIL B. WINC			07/15/2	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN ROAD FORT WAYNE, IN46815				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
IAG	evenings.	ESC IDENTIF TING INFORMATION)		IAG			DAIL
	The "Activities of Daily Living (ADL) Assistance (Algorithm), dated September 2010, indicated "When an activity occurs three times at any one given level, code that level" During an interview with the MDS nurse on 7/15/11 at 9:56 a.m., the MDS nurse indicated the coding she used was how she was trained when the program was first introduced. 3.1-31(d)						
F0323 SS=D	environment rema hazards as is poss receives adequate devices to prevent Based on observa interview, the fac medications were during a medicat Cove dining roor of 4 residents sea	ation, record review, and cility failed to ensure e not left unattended ion pass in the Maple m, potentially affecting 4 ated at the table (Resident 2, Resident #33, Resident	F03	323	It is the practice of this providensure that the resident environment remains as free accident hazards as is possile and each resident receives adequate supervision and assistance devices to preven accidents. What corrective action(s) will be accomplishe those residents found to have been affected by the deficien practice? Residents #29, #32	of ole; ut d for e t	08/13/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YFM811 Facility ID:

000282

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155755 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3136 GOEGLEIN ROAD **GOLDEN YEARS HOMESTEAD** FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE #33 and #38 had no negative outcomes as a result of the During an observation of a medication alleged deficient practice. Nurse pass by Nurse #2 on 7/12/11 at 4:45 P.M., #2 received one on one written on the Maple Cove unit (secured memory training with the DNS and Community Nurse Leader on July care unit), the nurse was observed to place 15, 2011. He has since oral medications into a paper medication resigned. How will you identify cup for Resident #29. Nurse #2 was other residents having the observed to take the medication cup to the potential to be affected by the table where Resident #29, Resident #32, same deficient practice and what corrective action will be Resident #33, and Resident #38 were taken?It is against Golden Years seated and then leave the cup on the table. Homestead's policy and At that time, Nurse #2 indicated that he procedure for licensed nurses to left the medications at the table because leave medications unattended Resident #29 would take them when she after administration therefore all residents who are not felt ready. Two other staff were observed self-administration of medications to be in the dining room passing plates are at risk. Nurse #2 received one and assisting residents at other tables. on one written training with the **DNS and Community Nurse** Leader on July 15, 2011. He has At 4:50 P.M..Nurse #2 was observed to since resigned.All licensed leave the Maple Cove Unit to continue the nurses will be in-serviced by medication pass on another unit. The oral the Director of Nursing Services medications for Resident #29 were still in or designees on July 28 and August 1, 2011 regarding this the paper medication cup Nurse #2 had provider's policy and procedure placed at her table. for "Administration of Oral Medication". What measures will The Unit Manager of Maple Cove, Nurse be put into place or what #3, was interviewed on 7/14/11 at 10:40 systemic changes you will make to ensure that the A.M. During the interview, Nurse #3 deficient practice does not indicated there were no residents on recur? Director of Nursing or Maple Cove capable of self administration designees will train all newly hired of medications. Nurse #3 further Licensed Nurses on this provider's policy and procedure indicated nurses administering for "Administration of Oral medications were to remain with the Medication". All licensed resident and observe the resident until the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155755	B. WIN			07/15/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
COLDEN	I YEARS HOMESTE	EAD.		1	OEGLEIN ROAD VAYNE, IN46815	
					VATNE, 11140819	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
1710		ed the medication. She	+	ing	nurses will be in-serviced by	DATE
		medications were not to			the Director of Nursing Servi	ces
					or designees on July 28 and	
	be left with the re	esident unattended.			August 1, 2011 regarding this	
	The Castly Disc	Anna CN maine (DON)			provider's policy and proced for "Administration of Oral	ure
		ctor of Nursing (DON)			Medication". How the correct	ctive
		7/14/11 at 11:00 A.M.			action(s) will be monitored	
	_	view, the DON indicated			ensure the deficient practic	e
	all residents on N	•			will not recur, i.e., what qua	-
		ired and none were			assurance program will be into place: Administrator,	put
	capable of self ac				Director of Nursing Services	or
		e DON further indicated			designee will monitor continu	
		ring medications were to			compliance through monthly	
	_	dent and observe the			random licensed nurse	
		medications were			medication pass observation months. The Administrator w	
	swallowed.				document findings on a Qual	I
					Improvement Tool and report	
		Resident #29, Resident			results of this audit to the Qu	· 1
	·	3, and Resident #38 were			Assurance committee who w	ill
		3/11 from 1:00 P.M. to			determine the frequency of further audits.	
		ecords indicated all the			or farther dudies.	
	residents had a d	iagnosis of dementia.				
	,	d "Administration of Oral				
		ed July 2011, indicated				
	"do not leave me	dications unattended."				
	3.1-45(a)(1)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155755 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3136 GOEGLEIN ROAD **GOLDEN YEARS HOMESTEAD** FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must -F0371 (1) Procure food from sources approved or SS=F considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based observation, record review, and F0371 It is the practice of this 08/13/2011 provider to procure food from interview, the facility failed to prevent sources approved or potential contamination of food by failing considered satisfactory by to ensure dietary staff properly washed Federal, State or local their hands for the recommended amount authorities; and store, prepare, distribute and serve food under of time during meal service and prior to sanitary conditions.What donning disposable gloves. The facility corrective action(s) will be also failed to ensure dietary staff washed accomplished for those their hands when moving from a soiled residents found to have been area to a clean area, used a clean towel to affected by the deficient dry out the canister of a clean blender and practice? There were no negative outcomes to any also ensure dietary staff did not chew gum resident as a result of the during meal service in 4 of 4 kitchens alleged deficient practice. How potentially affecting 103 of 103 residents will you identify other residents who ate meals prepared and served in the having the potential to be facility kitchens. affected by the same deficient practice and what corrective action will be taken?All residents have the potential to Findings include: be affected by the alleged deficient practice. All employees 1. On 7/11/11 from 11:15 A.M. until involved in food service operations will be in-serviced by 12:45 P.M., the following observations the Administrator, Culinary were made in the kitchen of the B Unit: Services Advisor and Registered Dietician on July 26, July 28 or At 11:15 A.M., Cook #5 was observed to August 1 and August 2, 2011. In-Service topics will be: Alleged remove gloves and reach into a bucket of deficient practices identified. sanitizing solution, remove a cloth, and Proper Culinary Services hand

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155755	B. WIN			07/15/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	OEGLEIN ROAD		
GOLDEN	YEARS HOMESTI	FΔD		1	VAYNE, IN46815		
				L	W/ (114E, 11440010		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	1 ^	of a metal serving cart.			washing policy and procedur glove usage policy and	e,	
	Cook #5 was the	n observed to wipe his			procedure, including proper		
	hands with the sa	ame cloth, don gloves,			procedure when moving from	n a	
	and begin dishin	g food onto plates with			soiled area to a clean area,	. ~	
	scoops. Cook #5	was not observed to			towel/rag usage, dress code		
	1 ^	r to donning the gloves.			policy and procedure to inclu	de	
	wash hands prior	to domining the groves.			no gum chewing. What		
	A4 11.20 A M	A : J = #4 a la ===== 4 4 a			measures will be put into p		
		Aide #4 was observed to			or what systemic changes y		
	l '	pe a counter surface.			will make to ensure that the	,	
		n observed to remove a			deficient practice does not	ما اس	
	clean blender car	nister from the			recur? All employees involve food service operations will be		
	dishwashing mad	chine. The blender			in-serviced by the Administra		
	canister had som	e soap bubbles on the			Culinary Services Advisor an		
	outside and insid	le of the blender canister.			Registered Dietician on July		
		n observed to wipe the			July 28 or August 1 and Aug		
		le of the blender canister			2011. Culinary Services Advi		
					will provide on the job trainin	-	
		oth that had been used to			teaching to each food service	9	
	_	nter surface. Cook #5			employee as needs are	an .	
		ed to use the blender			identified. Registered Dietici will complete monthly	all	
	canister to prepa	re pureed meat for one			observations and on the job		
	resident.				training to those employees		
					working during her visits. Hov	v the	
	At 11:25 A.M., (Cook #5 was observed to			corrective action(s) will be		
		oor while wearing gloves			monitored to ensure the		
	_	n of mashed potatoes.			deficient practice will not re		
	1	n observed to handle			i.e., what quality assurance		
					program will be put into	΄,	
	_	eal cards while wearing			place: Administrator, Culinar Services Advisor, Registered		
	_	k #5 was then observed to			Dietician or designees will	'	
		g of dinner rolls and, by			monitor continued compliance	e l	
	-	g the rolls with the same			through no less than monthly		
	gloves, remove t	he rolls from the bag and			random kitchen audits and		
	place the rolls or	nto plates for 18 of 20			employee observations		
	residents.				regarding the topics trained	41	
					during the in-services x 6 mc	INTINS.	

li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155755	B. WIN			07/15/2	U11
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
001.051		-40		1	OEGLEIN ROAD		
GOLDEN	I YEARS HOMESTE	=AD		FORT	VAYNE, IN46815		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		DATE
TAG	2 On 7/12/11 at kitchen, Dietary leaving the food on. The cook we retrieved items for sandwich: meat, Dietary Cook #14 and performed a before returning Also, Dietary Cowashing hands d for six seconds b supper to the residual on 7/12/11, observations were kitchen: At 4:19 p.m., Co	ervation of the evening the following re made in the "C" ok #8 was observed to		TAG	The Administrator will docum findings on a Quality Improvement Tool and report results of this audit to the Qu Assurance committee who w determine the frequency of further audits.	the ality	DATE
		For 8 seconds before					
	donning disposal preparation for the	ole gloves to continue ne evening meal.					
	-	de #9 was observed to . She was observed to . or 6 seconds.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155755	- 1	LDING		07/15/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			DEGLEIN ROAD		
GOLDEN	YEARS HOMESTI	EAD		1	VAYNE, IN46815		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		1 //0 1 1					
		ook #8 was observed to					
		or 7 seconds. She then					
	_	disposable gloves and					
		an dishing food onto					
	plates for the eve	ening meal.					
	4. During an obs	ervation of the evening					
	meal on 7/12/11,	, the following					
	· ·	e made in the "A" kitchen:					
	At 4:45 p.m., Co	ook #10 was observed to					
	leave the kitchen	and come into the dining					
	room to talk with	n a resident. She was					
	observed to place	e her gloved hands on the					
	table. She imme	ediately returned to the					
	kitchen to dish for	ood onto a plate for the					
	evening meal. S	he was not observed to					
	remove her dispo	osable gloves and wash					
	her hands before	continuing meal service.					
	At 4:47 p.m., Ai	de #11 was observed					
	1	itchen with the evening					
	meal service. He	e was observed chewing					
	gum.						
		1. //11 1 1.					
		de #11 was observed to					
		vening meal tray to a					
	resident room on						
	~	the "A" unit). He was					
		rn to the kitchen to					
		g with the evening meal					
		not observed to wash his					
	hands and was o	bserved chewing gum.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155755			LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED		
	PROVIDER OR SUPPLIER	EAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN ROAD FORT WAYNE, IN46815					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	return to the kitch common hallway was not observed immediately prepared and placific container and the into the microward observed to dish apples into desse was observed. At 4:55 p.m., Aid take a covered expression to deliver to deliver to was not observed to deliver to was not observed chewas obser	ok #10 started the vice for the Chestnut eighborhood on the "A" ot been observed to wash						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155755			LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/15/2	ETED	
	PROVIDER OR SUPPLIER		p. wiiv	3136 G	OEGLEIN ROAD VAYNE, IN46815		
(X4) ID PREFIX) ID SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		nager was interviewed on p.m. During the					
	•	licated dietary staff were ands upon entrance into the					
	kitchen and after	touching anything					
		ndicated disposable to be a substitute for					
	handwashing. H	ands were to be wet,					
		ne water for 20 seconds, He further indicated					
	dietary staff wer	e not to chew gum.					
	for Culinary Ser dated January 20 starting to work team members wVigorously get surfaces of the hincluding finger fingers, and back secondsHand w performed:Af equipment or ute gloves for working the current facility dated June 2009	ter handling soiled ensilsBefore putting on					
	No gum chewi	-					
	3.1-21(i)(3)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155755		(X2) MU A. BUII B. WIN	LDING G	NSTRUCTION 00	(X3) DATE S COMPL 07/15/2	ETED	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 GOEGLEIN ROAD				
GOLDEN	YEARS HOMESTE		FORT WAYNE, IN46815				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
F0386 SS=D	The physician musprogram of care, in treatments, at eac paragraph (c) of the date progress note and date all orders influenza and pnet vaccines, which me physician-approve assessment for compassed on record facility failed to a signed and dated of 21 residents recorders in a sample and #91) Findings include 1. Resident #104 on 7/14/11 at 8:4 indicated Resider included, but were blood pressure, compared to the progress of the	est review the resident's total including medications and hivisit required by his section; write, sign, and he sat each visit; and sign is with the exception of his aumococcal polysaccharide and he administered period facility policy after an intraindications. The review and interview, the ensure the physician hall physician orders for 2 eviewed for physician he of 21. (Resident #104) Et's record was reviewed for the factor of the	F0	386	It is the practice of this provider to have physicians review each resident's prog of care, including medicatic and treatments, at each visit required by paragraph (c) of this section; write, sign and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococci polysaccharide vaccines, which may be administered physician-approved facility policy after an aseesment for contraindications. What corrective action(s) will be accomplished for those residents found to have been	gram ons it f i f al	08/13/2011
	•	view, the monthly summary for December			affected by the deficient practice? Residents #91 and #104 had no negative outcomes as a result of the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155755	B. WING		07/15/2011
NAME OF I	DROWNER OF GUIDNIED		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	NAME OF PROVIDER OR SUPPLIER			OEGLEIN ROAD	
GOLDEN YEARS HOMESTEAD				WAYNE, IN46815	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	-	nt #104, were signed but		alleged deficient practice.	4:£: _ d
	not dated by the	physician.		Residents #91, #104's identification orders & summary were date.	I
				and signed. How will you	itea
	During record re	view, the following		identify other residents have	vina
	_	n orders summary were		the potential to be affected	<u> </u>
		ohysician: February		the same deficient practice	- I
		1, April 2011, May 2011,		what corrective action will	
	-	1, April 2011, May 2011,		taken?A 100% audit for the	
	and June 2011.			months of May, June and J	uly
				2011 orders and summaries	s of
				in-house residents was	
	2. Resident #91'	s record was reviewed on		completed by July 22, 2011	by
	7/13/11 at 1:50 p	.m. The record indicated		the RHIT. One finding	
	Resident #91's di	agnoses included, but		was signed and dated by the	
		to, depression, chronic		physician. What measures	s will
		onary disease, coronary		be put into place or what systemic changes you will	
	•	ronic kidney disease,		make to ensure that the	
		•		deficient practice does not	
	nigh blood press	ure and spinal stenosis.		recur? All licensed nurses w	I
				in-serviced on the following	
	_	view for Resident #91,		policies and procedures by t	he
	the following phy	ysician orders were		Director of Nursing on July 2	
	signed but not da	ted by the physician:		August 1, 2011: General Po	olicies
	6/16/11 order for	ointment medication		and Month End/Re-Write	
	6/21/11 order for	anxiety medication		protocol. Licensed Nurses v obtain required information of	
		anxiety medication		physician visits. The RHIT wi	-
		pain relief medication		a month end audit of summa	l l
		depression medication		and orders of those resident	
		-		were seen during the curren	I
		medication change		month to ensure they are sig	
		an orders summary for		and dated. How the correcti	
	June 2011			action(s) will be monitored	l l
				ensure the deficient practic	l l
	During record re	view for Resident #91,		will not recur, i.e., what qua	-
	_	sician orders summary		assurance program will be	put
		y the physician for April		into place: Administrator, Director of Nu	ırsina
	2011 and May 20			Services or designees will	
	2011 and Iviay 20	/11.	1	1 23171000 01 4001911000 WIII	I

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155755		LDING	00	07/15/2	
		100700	B. WIN		A DDDEGG CITY CTATE ZID CODE	0771072	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OEGLEIN ROAD		
GOLDEN	I YEARS HOMESTE	EAD		1	VAYNE, IN46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	CROSS-REFERENCED TO THE APPROPRIATI		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	,		DATE
	During record retails the following physician. Month individual order a residentIn discharged charts completed in a tin individual order a practitioner: 5/20/11 order for 5/20/11 order for 5/20/11 order for 5/20/11 order for care and pain materials. On 7/15/11 at 8:3 Facility Administrated "Month" and indicated the currently used by included, "have physician's order. On 7/15/11 at 8:3 Facility Administrated the political political order and acceptable and accep	view for Resident #91, ysician orders were physician or nurse morphine morphine home health to provide nagement 30 a.m., the Health trator provided the End/Re-write protocol" policy was the one the facility. The policy the physician sign the s" 30 a.m., the Health trator provided the policy the physician sign the s" 30 a.m., the Health trator provided the policy the policy was the one currently trator provided the policy s," dated 8/2009, and the was the one currently try. The policy indicated, Homestead maintains th			monitor continued compliance through no less than monthly random chart audits x 6 more. The Administrator will docume findings on a Quality. Improvement Tool and report results of this audit to the Quant Assurance committee who was determine the frequency of further audits.	ths. nent t the nality	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155755	A. BUILDING		07/15/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			OEGLEIN ROAD	
	I YEARS HOMESTE		FORT V	VAYNE, IN46815	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
	3.1-22(c)(3)	,			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 00 COMPL			COMPL	ETED
		155755	B. WING	,		07/15/20	011
				REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L	I		DEGLEIN ROAD		
GOLDEN	I YEARS HOMESTE	EAD			/AYNE, IN46815		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAC	G	DEFICIENCY)		DATE
F0441 SS=E		establish and maintain an Program designed to provide					
00 L		nd comfortable environment					
		nt the development and					
	transmission of dis	sease and infection.					
	(a) Infection Contro	rol Program					
		establish an Infection Control					
	Program under wh						
		ontrols, and prevents					
	infections in the fa	orocedures, such as					
		e applied to an individual					
	resident; and	o applied to all marriada.					
	(3) Maintains a red	cord of incidents and					
	corrective actions	related to infections.					
	(b) Preventing Spr	read of Infection					
		ction Control Program					
	` '	resident needs isolation to					
		d of infection, the facility					
	must isolate the re						
		st prohibit employees with a ease or infected skin					
		t contact with residents or					
		contact will transmit the					
	disease.						
		st require staff to wash their					
		direct resident contact for ng is indicated by accepted					
	professional practi	• • •					
	F. S. SSS. Silai piaoti						
	(c) Linens						
		andle, store, process and					
	transport linens so infection.	as to prevent the spread of					
		ation, record review, and	F0441		This provider has an		08/13/2011
	interview, the fac	cility failed to ensure 1 of			established Infection Contro	ol	
	4 nursing staff wa	ashed hands while			Program that maintains a program designed to provide	ا ءا	
	administering me	edications, potentially			safe, sanitary and comforta		
	affecting 6 of 30	residents observed for			environment and helps prev		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155755		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE: COMPL 07/15/2	ETED	
NAME OF	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDE	N YEARS HOMEST	EAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the administration #2, Resident #29 #50). Findings included During a continual medication pass memory care unterpolation pass memory care unterpolation pass memory care unterpolation pass memory care unterpolation pass and to pass At 4:45 P.M., Note the dining room "neighborhood" care unith administic action and the pass part of the pass part of the pass part of the pass pass pass pass pass pass pass pas	on of medications. (Nurse 2, #40, #42, #44, #45, and 2) and observation of a on the B Unit (secured it) on 7/12/11 from 4:45 P.M., Nurse #2 was medications to residents. The secured memory istering oral medications are medications. The nurse was not in hands or to use hand ministering the surse #2 was then observed cove and proceed through doors and enter Hickory neighborhood" on the care unit) to administer me residents in that dining			the development and transmission of disease ar infection. This provider's Infection Control Program includes preventing the spot of infection and proper line handling. What corrective action(s) will be accomplis for those residents found have been affected by the deficient practice? Reside #29, #40, #42, #44, #45 and had no negative outcomes result of the alleged deficient practice. Nurse #2 received one on one written training with the DNS and Commun Nurse Leader on July 15, 2. He has since resigned. How you identify other resident having the potential to be affected by the same deficing practice and what correcting action will be taken? All residents living in Communi B had the potential to be affected by the alleged deficient practice and what correcting action will be taken? All residents living in Communi B had the potential to be affected by the alleged deficient practice and what correcting action will be in-service to any resident. All employed involved in medication administration and food services Advisor and Regis Dietician on July 26, July 28 August 1 and August 2, 201 In-Service topics will be: All deficient practices identified Proper Culinary Services has washing policy and proceduration and procedurat	also read en hed o hts #50 as a ent d J hity 011. v will s ient ve ected ctice. rred es vice d by tered or 1. teged n hed o	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155755 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3136 GOEGLEIN ROAD **GOLDEN YEARS HOMESTEAD** FORT WAYNE, IN46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Nurse #7 was interviewed on 7/14/11 at procedure, including proper procedure when moving from a 10:30 A.M. During the interview, Nurse soiled area to a clean area. #7 indicated nurses were to either use towel/rag usage, dress code hand sanitizer or wash hands with soap policy and procedure to include no gum chewing. All employees and water before and after administering will be also be in-serviced on medications to residents and in between Washing Hands with Alcohol each resident contact. Sanitizer and Indications for Hand Washing when Providing Direct The facility Director of Nursing (DON) Care to a resident Policies and Procedures. Return was interviewed on 7/14/11 at 11:00 A.M. demonstrations will be required During the interview, the DON indicated from all employees. All Licensed nurses were expected to use hand sanitizer Nurses in-servicing will include all or wash hands with soap and water while of the above topics and this provider's Oral Administration of administering medications to residents. Medications Policy and Procedure. What measures will A facility policy entitled "Administration be put into place or what of Oral Medications", dated July 2011, systemic changes you will indicated "wash hands before preparing make to ensure that the deficient practice does not medications for administration." recur? All employees including all licensed nurses will be 3.1-18(1)trained on the topics listed above and will be randomly audited for proper policy and procedure compliance. Director of Nursing Services or designees will provide on the job training and teaching to licensed nurses as individual needs are identified. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, Director of Nursing Services or designees will monitor continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155755	B. WING		07/15/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
001 0511 751 00 110 1151 5151 5				OEGLEIN ROAD	
	NYEARS HOMESTE	EAD	FORT	WAYNE, IN46815	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG		Ditte
TAG		LSC IDENTIFYING INFORMATION)	TAG	compliance through no less monthly random medication administration audits and employee observations regarding the topics trained during the in-services x 6 mc The Administrator will docum findings on a Quality Improvement Tool and repor results of this audit to the Qu Assurance committee who w determine the frequency of further audits.	than onths. nent t the eality